DWS-UI FORM 617 REV 11/07

UTAH DEPARTMENT OF WORKFORCE SERVICES

APPEAL FROM DECISION OF REPRESENTATIVE

P.O. Box 45244 Salt Lake City, UT 84145-0244 (801)526-9300 (801)526-9242 Fax

SOCIAL SECURITY NUMBER CLAIMANT'S NAME CLAIMANT'S STREET OR P.O. BOX TELEPHONE NUMBER [] Check here if new address **APPEAL FILED BY:** STATE ZIP CITY [] Claimant [] Employer [Other (specify) I DISAGREE with the decision of a Department representative dated_ which allowed/denied (circle one) benefits effective (date)_ __under of the Utah Employment Security Act. The grounds for this appeal are: Section I am requesting the following relief through this appeal: [] Allowance of unemployment benefits effective (date) _____ Denial of unemployment benefits effective (date) [] Relief of benefit cost charges. [] Other (explain) _

Place your initials at the end of your statement. Use the reverse side if you need more space. This appeal can only be signed by the person claiming benefits, the employer, or another interested party.

I UNDERSTAND that copies of this appeal will be sent to other interested parties and that an appeal hearing will be scheduled if the decision is not changed by the Department review authority.

Appellant's Signature	Date	
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CONTINUATION OF APPEAL STATEMENT

CLAIMANT'S NAME	TELEPHONE NUMBER

Appellant's Signature